Substitute per letter dated SEP 23 1998

Rental Value	$ 108,289
Rate of Return	$ 185,853
Computed Interest	$ 207,840
Total	$ 501,982
Divided by Annualized Patient Days	56,077
Capital Per Diem	$ 8.95

B. A per diem is calculated by dividing the pass through expenses by the greater of the minimum utilization as determined in subsection (7)(O) or the facility's patient days from the rate setting cost report. The following is an illustration of how subparagraph (11)(D)4.B. is calculated:

Pass Through Expenses	$ 48,142
Patient Days	55,146
Pass Through Per Diem	$ .87

C. The capital component per diem is the sum of subparagraph (11)(D)4.A. and (11)(D)4.B.

Capital Per Diem	$ 8.95
Pass Through Per Diem	$ .87
Total Capital Component Per Diem	$ 9.82

(E) Working Capital Allowance. Each HIV nursing facility's working capital per diem shall be equal to one and one-tenth (1.1) months of each facility's per diem for patient care, ancillary and administration times the Chase Manhattan prime rate on July 3, 1995, plus two percentage (2%) points. The following is an illustration of how subsection (11)(E) is calculated:

Patient Care	$ 30.00
Ancillary	$ 7.00
Administration	$ 20.00
Total Per Diem	$ 57.00
divided by 12 months	12
	$ 4.75
Times 1.1 months	1.1
	$ 5.23
Times Prime + 2% (Chase Manhattan plus 2%)	11%
Working Capital Allowance per day	$ .58

(F) The following is an illustration of how subsections (11)(A), (11)(B), (11)(C), (11)(D) and (11)(E) determine the per diem rate:

	Allowable	Cost Ceiling	Per Diem
Patient Care	$38.00	$40.00	$38.00
Ancillary	$ 8.00	$ 6.00	$ 6.00
Administration	$12.00	$11.00	$11.00
Capital (FRV)			$ 9.82
Working Capital Allowance			$ .58
Total Per Diem			$65.40

(12) Reimbursement Rate Determination. A HIV nursing facility's reimbursement rate shall be determined by the Division as described in sections (11), (12), (13) and (14), subject to limitations prescribed elsewhere in this plan.

(A) A facility entering the Medicaid Program after November 30, 1995, shall receive an interim rate as defined in subsection (4)(FF) to be effective on the initial date of Medicaid certification. A prospective rate shall be determined in accordance with section (11) from the desk audited and/or field audited facility fiscal year cost report which covers the second full twelve (12) month fiscal year following the facility's initial date of Medicaid certification. This prospective rate shall be retroactively effective and shall replace the interim rate for services beginning on the first day of the facility's second full twelve (12) month fiscal year.

(B) A facility with a valid Medicaid participation agreement in effect after November 30, 1995, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which re-enters the Medicaid Program, shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted with effective dates subsequent to the termination date but prior to re-entry into the program as described in subsection (13)(A). This prospective rate shall be effective for service dates on and after the effective date of the re-entry following a voluntary or involuntary termination.

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this plan, a facility's reimbursement rate may be adjusted as described in this section.

(A) Global per diem rate adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments (i.e., trend factors). Global per diem rate adjustments shall be added to the specified cost component ceiling.

(B) Special per diem rate adjustments. Special per diem rate adjustment may be added to a qualifying HIV nursing facility's rate without regard to the cost component ceiling if specifically provided as described below.

1. Replacement Beds. A facility with a prospective rate in effect after November 30, 1995, may request a rate adjustment for replacement beds that resulted in the same number of beds being delicensed with the Division of Aging. The facility shall provide documentation from the Division of Aging that verifies the number of beds used for replacement have been delicensed from that facility. The rate adjustment will be calculated as the difference between the capital component per diem (Fair Rental Value, FRV) prior to the replacement beds being placed in service and the capital component per diem (Fair Rental Value, FRV) including the replacement beds placed in service as calculated in subsection (11)(D) including the replacement beds placed in service. The capital component is calculated for the replacement beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the replacement beds are placed in service.

2. Additional Beds. A facility with a prospective rate in effect after November 30, 1995, may request a rate adjustment for additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The rate adjustment will be calculated as the difference between the capital component per diem (Fair Rental Value, FRV) prior to the additional beds being placed in service and the capital component per diem (Fair Rental Value, FRV) including the additional beds as calculated in subsection (11)(D) including the additional beds placed in service. The capital component is calculated for the additional beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the additional beds are placed in service.

3. Extraordinary Circumstances. A participating facility which has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request must be submitted in writing to the Division within one (1) year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment must be supported by complete, accurate

and documented records satisfactory to the Division. If the Division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the Division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

A. When the provider can show that it incurred higher costs due to circumstances beyond its control, the circumstances were not experienced by the nursing home industry in general and the costs have a substantial cost effect.

B. Extraordinary circumstances include:

(I) Natural disasters such as fire, earth-quakes and flood that are not covered by insurance and that occur in a federally declared disaster area; and

(II) Vandalism and/or civil disorder that are not covered by insurance.

C. The rate increase shall be calculated as follows:

(I) The one (1) time costs, (costs that will not be incurred in future fiscal years):

(a) To determine what portion of the incurred costs will be paid, the Division will use the patient occupancy days from latest available quarterly occupancy survey from the Division of Aging for the time period preceding when the extraordinary circumstances occurred; and

(b) The costs directly associated with the extraordinary circumstances will be multiplied by the above percent. This amount will be divided by the paid days for the month the rate adjustment becomes effective per paragraph (13)(B)3. This calculation will equal the amount to be added to the prospective rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one (1) month only, the ceiling will be waived.

(II) For on going costs (costs that will be incurred in future fiscal years): On going annual costs will be divided by the greater of: annualized (calculated for a twelve (12) month period) total patient days from the latest cost report on file or eighty-five percent (85%) of annualized total bed days. This calculation will equal the amount to be added to the respective cost center, not to exceed the cost component ceiling. The rate adjustment, subject to ceiling limits will be added to the prospective rate.

(III) For capitalized costs, a capital component per diem (Fair Rental Value, FRV) will be calculated as determined in subsection (11)(D). The rate adjustment will be calculated as the difference between the capital component per diem (Fair Rental Value, FRV) prior to the extraordinary circumstances and the capital component per diem (Fair Rental Value, FRV) including the extraordinary circumstances.

(C) Conditions for prospective rate adjustments. The Division may adjust a facility's prospective rate both retrospectively and prospectively under the following conditions:

1. Fraud, misrepresentation, errors. When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's prospective rate may be both retroactively and prospectively reduced if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a higher, prospective rate than the facility would have received in the absence of such information. No decision by the Division to impose a rate adjustment in the case of fraudulent, misrepresented or inaccurate information shall in any way affect the Division's ability to impose any sanctions authorized by statute or regulation. The fact that fraudulent, misrepresented or inaccurate information reported did not result in establishment of a higher prospective rate than the facility would have received in the absence of this information also does not affect the Division's ability to impose any sanctions authorized by statute or regulation;

2. Decisions of the Administrative Hearing Commission, or settlement agreements approved by the Administrative Hearing Commission;

3. Court Order; and

4. Disallowance of federal financial participation.

(14) Exceptions.

(A) For those Medicaid-eligible recipients who have concurrent Medicare Part A skilled nursing facility benefits available, Medicaid reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.

(15) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this plan, the Division may also impose sanctions against a provider in accordance with state regulation 13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for Title XIX Services, or any other sanction authorized by state or federal law or regulations.

(B) Overpayments due the Medicaid Program from a provider shall be recovered by the Division in accordance with state regulation 13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for Title XIX Services.

(16) Appeals. In accordance with sections 208.156, RSMo 1986, and 622.055, RSMo (Supp. 1989), providers may seek hearing before the Administrative Hearing Commission of final decisions of the Director or the Division.

(17) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these State Plan and other applicable payments.

(18) Provider Participation. Payments made in accordance with the standards and methods described in this plan are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these services are available to the general public.

(19) Transition. Cost reports used for rate determination shall be adjusted by the Division in accordance with the applicable cost principles provided in this plan.

Substitute per letter dated SEP 2 2 1998

APPENDIX A

COVERED SUPPLIES AND SERVICES PERSONAL CARE

Baby powder
Bedside tissues
Bibs, all types
Deodorants
Disposable underpads of all types
Gowns, hospital
Hair care, basic including washing, cuts, sets, brushes, combs, non-legend shampoo
Lotion, soap, and oil
Oral hygiene including denture care, cups, cleaner, mouthwashes, tooth brushes and paste
Shaves, shaving cream and blades
Nail clipping and cleaning-routine

EQUIPMENT

Arm slings
Basins
Bathing equipment
Bed frame equipment including trapeze bars and bedrails
Bed pans, all types
Beds, manual, electric
Canes, all types
Crutches, all types
Foot cradles, all types
Glucometers
Heat cradles
Heating pads
Hot pack machines
Hypothermia blanket
Mattresses, all types
Patient lifts, all types
Respiratory equipment: compressors, vaporizers, humidifiers, IPPB machines, nebulizers, suction equipment and related supplies, etc.
Restraints
Sand bags
Specimen container, cup or bottle
Urinals, male and female
Walkers, all types
Water pitchers
Wheelchairs, standard, geriatric and rollabout

*Substitute per letter dated SEP 23 1998

NURSING CARE/PATIENT CARE SUPPLIES

Catheter, indwelling and non-legend supplies
Decubitus ulcer care: pads, dressings, air mattresses, aquamatic K pads (water heated pads), alternating pressure pads, flotation pads and/or turning frames, heelprotectors, donuts and sheepskins
Diabetic blood and urine testing supplies
Douche bags
Drainage sets, bags, tubes, etc.
Dressing trays and dressings of all types
Enema supplies
Gloves, non-sterile and sterile
Ice bags
Incontinency care including pads, diapers and pants
Irrigation trays and non-legend supplies
Medicine droppers
Medicine cups
Needles including but not limited to hypodermic, scalp, vein
Nursing services: regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel
Nursing supplies: lubricating jelly, betadine, benzoin, peroxide, A and O ointment, tapes, alcohol, alcohol sponges, applicators, dressings and bandages of all types, cottonballs, and aerosol merthiolate, tongue depressors
Ostomy supplies: adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures, and bags
Suture care including trays and removal kits
Syringes, all sizes and types including ascepto
Tape for laboratory tests
Urinary Drainage Tube and Bottle

THERAPEUTIC AGENTS AND SUPPLIES

Supplies related to internal feedings
I.V. therapy supplies: arm boards, needles, tubing, and other related supplies
Oxygen, (portable or stationary), oxygen delivery systems, concentrators, and supplies
Special diets

Medical Services so appropriate payment can be determined.

(4) Payment for authorized hospital leave days shall be at the per-diem rate for the respective provider.

(5) For each day that Medicaid reimburses a nursing facility, pursuant to this subsection, the Medicaid recipient shall be ineligible for reimbursement to nursing facilities for two otherwise available temporary leave of absence days as described in 13 CSR 70-10.010(5)(D). The total hospital leave days and temporary leave of absence days shall not exceed the limits for the periods defined in 13 CSR 70-10.010(5)(D).

AUTHORITY: sections 208.153, RSMo (Cum. Supp. 1991), 208.159, RSMo (1986) and 208.201, RSMo (Supp. 1987). Emergency rule filed Dec. 17, 1993, effective Dec. 27, 1993, expired April 25, 1994. Emergency rule filed April 15, 1994, effective May 1, 1994, expired Aug. 28, 1994. Original rule filed Nov. 2, 1993, effective June 6, 1994.*

**Original authority: 208.153, RSMo (1967), amended 1973, 1989, 1990, 1991; 208.159, RSMo (1979); and 208.201, RSMo (1987).*

13 CSR 70-10.070 Limitations on Allowable Nursing Facility Costs to Reserve a Bed for Absences Due to Hospital Admission

PURPOSE: This rule outlines the coverage of nursing facility costs to reserve a bed in a nursing facility during an absence from the facility due to a hospital admission of three days or less and the limitations related to that coverage.

(1) Payment to a nursing facility (NF) for hospital leave days is authorized for days in [illegible] a Medicaid recipient is absent from the [illegible]e to admission to a hospital for services [illegible]n cannot be performed on an outpatient basis, subject to the following:

(A) The nursing facility in which the Medicaid resident resides is licensed under Chapter 198, RSMo;

(B) The NF is in compliance with all federal and state certification standards;

(C) The occupancy rate of the NF is at or above ninety-seven point zero percent (97.0%), rounded to four (4) decimal places, of Medicaid certified licensed beds, for the quarter prior to the first day of services provided based on the census for that quarter provided from the Division of Aging to the Division of Medical Services;

(D) The Medicaid recipient is admitted to a hospital for a medical condition, which cannot be treated on an outpatient basis, with a total stay of three (3) days or less; and

(E) The hospital provides a discharge plan for the recipient which includes returning to the facility requesting the hospital leave days.

(2) The payment for hospital leave days shall only be provided for qualified hospital stays of three (3) days or less. A qualified hospital [illegible] one in which the medical condition [illegible]be treated on an outpatient basis.

(3) The hospital leave days billed by the nursing facility shall be held in suspense until the nursing home bill, hospital bill and quarterly census has been received by the Division of

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APPENDIX

Findings and Assurances

In conformity with the Title 42 CFR Section 447.253(a) and (b), the Department of Social Services/Division of Medical Services (DSS/DMS) makes the following findings and assurances:

- Long-term care facility rates of payment have been found to be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

- The estimated weighted average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement, per 447.272(a).

- The estimated weighted average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services to state-operated facilities than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement, per 447.272(b).

- DSS/DMS provides long-term care facilities with an appeal or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of payment rates with respect to such issues as DSS/DMS determines appropriate.

- DSS/DMS requires the filing of uniform cost reports by each participating provider.

- DSS/DMS provides for periodic audits of the financial and statistical records of participating providers.

- DSS/DMS has complied with the public notice provisions of 447.205

- DSS/DMS pays for long-term care services using rates determined in accordance with methods and standards specified in the approved State Plan.

- The payment methodology used by the State for payments to long-term care facilities for medical assistance can reasonably be expected not to increase payments solely as a result of a change of ownership in excess of the increase which would result from application of 42 U.S.C. 1861 (v)(1)(0) of the Social Security Act for all changes of ownership which occur on or after July 18, 1984, except for those changes made pursuant to an enforceable agreement executed prior to that date.

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